Welcome!

This is your opportunity to be counted as a valuable mental health provider in Montana!

The Montana Department of Public Health and Human Services is conducting a survey of all mental health providers in Montana in order to identify areas in Montana that need additional funding or services for mental health care. All survey responses will be analyzed to designate and score Health Professional Shortage Area (HPSA) designations. All responses are confidential.

If you have any questions or concerns please contact Ann Buss at 406-444-4119 or abuss@mt.gov, or visit http://dphhs.mt.gov/publichealth/primarycare.

About YOU

* 1. What is your name, or if you an office manager, what is the name of the mental health provider for whom you are answering?

Title

First name

Middle Initial

Last name

Suffix

At what email address and telephone number may DPHHS contact you?

2. Email address

3. Telephone number

4. What is the status of your Montana practice? (select one response)

- ○ Actively working (full-time or part-time) in a position that requires a mental health license
- ○ Volunteer in a position that requires a mental health license
- ○ Only working in a field that does NOT require a mental health license
- ○ Not currently working
- ○ Retired
- ○ Other (please specify)

Primary Practice Location

* 5. What is your PRIMARY practice address?
(physical practice location, not mailing address)

Address:

Address 2:

City/Town:

State: -- select state --

ZIP:

Phone Number:

6. Please provide the following information about your practice manager at this location.

Name:

Email Address:

Phone Number:

* 7. Please indicate the type of mental health license you practice at this location.

- ○ Allopathic or Osteopathic Physicians- Psychiatry (MD or DO)
- ○ Health Service Psychologist (HSP)
- ○ Licensed Clinical Social Worker (LCSW)
- ○ Licensed Professional Counselor (LPC)
- ○ Marriage and Family Therapist (MFT)
- ○ Psychiatric Nurse Specialist (PNS)
- ○ Nurse Practitioner (NP)
- ○ Physician Assistant (PA)
- ○ Other (please specify)

* 8. What type of provider are you at this location?
(check all that apply)

- ☐ Private Provider
- ☐ National Health Service Corp (NHSC) Provider
- ☐ Indian Health Services (IHS)/Tribal Provider
- ☐ Federal Employee
- ☐ Federally Qualified Health Center (FQHC)/Community Health Center (CHC) Provider
- ☐ Volunteer
- ☐ Other (please specify)

* 9. Please indicate the average number of hours per week spent on each major activity at this location.

Clinical care (one-on-one with patients)

Research

Teaching/education (NOT one-on-one with patients)

Administrative

* 10. Please indicate the average number of weeks per year you practice at this location.

* 11. Are you currently accepting new patients at this location?

- ○ Yes, ALL new patients
- ○ Yes, but ONLY a limited number of Medicaid patients
- ○ Yes, but NO Medicaid patients
- ○ No

If "Yes, but ONLY a limited number of Medicaid patients," please indicate how many Medicaid patients you are willing to accept.

* 12. Do you offer a sliding fee scale at this location?

- ○ Yes
- ○ Yes, but ONLY partially
- ○ No

If "Yes, but ONLY partially," please describe the sliding fee scale you implement.

13. Please indicate for the following populations:

	Do you serve:	Approximate percentage of:
Medicaid patients		
Sliding fee scale patients		
Homeless patients		
Migrant worker patients		
Tourists patients		
Seasonal resident patients		
American Indian or Alaska Native patients		

* 14. Is language interpretation offered at this practice location?

- ○ Yes
- ○ No

If "Yes," please specify languages offered

15. How many outpatient visits do you perform from this location per year? This refers to the total number of visits and not the number of distinct patients seen. For example, four appointments with the same patient counts as four visits.

16. Please indicate the percentage of your patients that

suffer from alcoholism

have substance abuse problems

* 17. Do you have a secondary practice location in Montana?

- ○ Yes
- ○ No

Secondary Practice Location

* 18. What is your SECONDARY practice address?
(physical practice location, not mailing address)

Address:

Address 2:

City/Town:

State: -- select state --

ZIP:

Phone Number:

19. Please provide the following information about your practice manager at this location.

Name:

Email Address:

Phone Number:

* 20. Please indicate the type of mental health license you practice at this location.

- ○ Allopathic or Osteopathic Physicians- Psychiatry (MD or DO)
- ○ Health Service Psychologist (HSP)
- ○ Licensed Clinical Social Worker (LCSW)
- ○ Licensed Professional Counselor (LPC)
- ○ Marriage and Family Therapist (MFT)
- ○ Psychiatric Nurse Specialist (PNS)
- ○ Nurse Practitioner (NP)
- ○ Physician Assistant (PA)
- ○ Other (please specify)

* 21. What type of provider are you at this location?
(check all that apply)

- ☐ Private Provider
- ☐ National Health Service Corp (NHSC) Provider
- ☐ Indian Health Services (IHS)/Tribal Provider
- ☐ Federal Employee
- ☐ Federally Qualified Health Center (FQHC)/Community Health Center (CHC) Provider
- ☐ Volunteer
- ☐ Other (please specify)

* 22. Please indicate the average number of hours per week spent on each major activity at this location.

Clinical care (one-on-one with patients)	
Research	
Teaching/education (NOT one-on-one with patients)	
Administrative	

* 23. Please indicate the average number of weeks per year you practice at this location.

* 24. Are you currently accepting new patients at this location?

- ○ Yes, ALL new patients
- ○ Yes, but ONLY a limited number of Medicaid patients
- ○ Yes, but NO Medicaid patients
- ○ No

If "Yes, but ONLY a limited number of Medicaid patients," please indicate how many Medicaid patients you are willing to accept.

25. Please indicate for the following populations:

	Do you serve:	Approximate percentage of:
Medicaid patients		
Sliding fee scale patients		
Homeless patients		
Migrant worker patients		
Tourists patients		
Seasonal resident patients		
American Indian or Alaska Native patients		

* 26. Do you offer a sliding fee scale at this location?

- ○ Yes
- ○ Yes, but ONLY partially
- ○ No

If "Yes, but ONLY partially," please describe the sliding fee scale you implement.

* 27. Is language interpretation offered at this practice location?

- ○ Yes
- ○ No

If "Yes," please specify languages offered

28. How many outpatient visits do you perform from this location per year? This refers to the total number of visits and not the number of distinct patients seen. For example, four appointments with the same patient counts as four visits.

29. Please indicate the percentage of your patients that

suffer from alcoholism

have substance abuse problems

* 30. Do you have three or more practice locations in Montana?

- ○ Yes
- ○ No

Future Plans and Demographics

31. Regarding future career planning, do you anticipate to (check all that apply):

	Within 1 year	Within 2 to 5 years
Retire	○	○
Cut back on hours/patients seen	○	○
Increase hours/patients seen	○	○
Add an associate/partner to your practice	○	○
Close your practice to new patients	○	○
Seek a non-clinical job	○	○
Move to another location in Montana	○	○
Move out of state	○	○
Continue practicing as I am	○	○

If you plan to make any changes within the next year, please briefly state your reasons for doing so

32. In what year were you born?

33. What is your gender?

- ○ Female
- ○ Male

34. Which race/ethnicity best describes you?

- ○ American Indian or Alaskan Native
- ○ Asian/Pacific Islander
- ○ Black or African American
- ○ Hispanic American
- ○ White/Caucasian
- ○ Other (please specify)

35. Please provide any additional comments or questions.

You have completed the survey. Thank you for your time! Your responses will help the Montana Department of Public Health and Human Services, Montana Primary Care Office to identify medically underserved areas or health professional shortage areas and bring additional funding into the state to support mental and behavioral health.

For more information or questions please contact:

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Phone 406-444-4119
Web site: http://dphhs.mt.gov/publichealth/primarycare/-Shortage-Area-Designations